

Exhibit 1

Begin forwarded message:

From: "Casavant, Aaron J CDR USCG CG ACADEMY (USA)" <Aaron.J.Casavant@uscg.mil>
Date: March 6, 2023 at 10:31:29 AM AKST
To: "Casavant, Aaron J CDR USCG CG ACADEMY (USA)" <Aaron.J.Casavant@uscg.mil>
Cc: "Ray, Arthur L CAPT USCG (USA)" <Arthur.L.Ray@uscg.mil>, "Janaro, Jeffrey G CDR USCG CG ACADEMY (USA)" <Jeff.G.Janaro@uscg.mil>, "Mattoon, Amanda S CIV USCG CG ACADEMY (USA)" <Amanda.S.Mattoon@uscg.mil>
Subject: Potential Readmission to the U.S. Coast Guard Academy

Good afternoon,

I am writing to summarize last week's conversation (or phone message) regarding potential readmission to the Coast Guard Academy (CGA) in light of the Coast Guard's rescission of the Covid-19 vaccine mandate. In addition to what I will cover in this email, I have also attached the latest version of the CGA Readmission Policy, which is the document that will guide CGA actions during your potential return to campus.

Should you desire to be readmitted to CGA, please submit a letter request in accordance with paragraph 11 of the attached SUPTINST. Note that you should submit the letter request to me via email (rather than the Director of Admissions). In the letter request, please indicate your preferred timeline for return to CGA (e.g., ASAP, at the conclusion of the spring semester, etc.). Please also describe any educational credits you have earned while separated from CGA to allow the Academics Division to analyze how best to re-enroll you in classes. In addition, please list any collegiate sports you have played while separated from CGA to allow the Athletics Division to accurately assess your NCAA eligibility.

To be clear, this email is not a guarantee that you will be re-admitted to CGA, but rather an invitation to re-apply and a notification that your previous refusal to take the Covid-19 vaccine no longer bars you from serving in the Coast Guard or completing the cadet training program. Your timeline for graduation will be presented to you based on the information you provide to CGA and your status at the time of your disenrollment.

I look forward to hearing from you.

v/r,

3/14/23, 1:51 PM

Mail - Daisy Chung - Outlook

CDR Aaron Casavant

Begin forwarded message:

From: "Casavant, Aaron J CDR USCG CG ACADEMY (USA)" <Aaron.J.Casavant@uscg.mil>
Date: March 6, 2023 at 14:31:24 EST
To: "Casavant, Aaron J CDR USCG CG ACADEMY (USA)" <Aaron.J.Casavant@uscg.mil>
Cc: "Ray, Arthur L CAPT USCG (USA)" <Arthur.L.Ray@uscg.mil>, "Janaro, Jeffrey G CDR USCG CG ACADEMY (USA)" <Jeff.G.Janaro@uscg.mil>, "Mattoon, Amanda S CIV USCG CG ACADEMY (USA)" <Amanda.S.Mattoon@uscg.mil>
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3/14/23, 1:49 PM

Mail - Daisy Chung - Outlook

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I look forward to hearing from you.

v/r,

CDR Aaron Casavant

Exhibit 2

**U.S. Department of
Homeland Security**

**United States
Coast Guard**



Superintendent
United States Coast Guard
Academy

15 Mohegan Avenue
New London, CT 06320
Staff Symbol: (spl)
Phone: (860) 701-6874

SUPTINST 1531.1A
25 FEB 2023

SUPERINTENDENT INSTRUCTION 1531.1A

Subj: COAST GUARD ACADEMY READMISSION POLICY

- Ref:
- (a) Accession (ACC-19) – Acknowledgment of Recoupment Law and Policy
 - (b) Obligated Service or Recoupment from Cadets Disenrolled from the Coast Guard Academy, SUPTINST 5340.3A
 - (c) Cadets: Requirements for Admission, 10 U.S.C. § 7446
 - (d) Medical Standards for Appointment, Enlistment, or Induction in the Military Services, DoDI 6130.03, Vol. 1
 - (e) Regulations for the Corps of Cadets, SUPTINST M5215.2O

1. **PURPOSE.** This instruction establishes policy and guidance for readmission to the Coast Guard Academy (CGA) after disenrollment, involuntary termination of a cadet appointment, or approved sabbatical.
2. **ACTION.** Former cadets desiring to be readmitted to CGA shall ensure eligibility in accordance with references (a) - (c) and follow the procedures outlined in this instruction. Internet release is authorized.
3. **DIRECTIVES AFFECTED.** None.
4. **DISCUSSION.** Readmission affords former cadets an additional opportunity to graduate and commission as officers in the U.S. Coast Guard. While readmission to CGA is not a guarantee that a cadet will graduate, it nevertheless allows CGA to benefit from the resources already invested in readmission applicants.
5. **DISCLAIMER.** This guidance is not a substitute for applicable legal requirements, nor is it itself a rule. It is intended to provide operational guidance for Coast Guard personnel and is not intended to nor does it impose legally binding requirements outside the Coast Guard.
6. **ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS.** Environmental considerations were examined in the development of this instruction and have been determined to be not applicable.
7. **DISTRIBUTION.** No paper distribution will be made of this instruction. An electronic version will be located on the CGA Portal website in the General Links section for Superintendent Instructions.

8. **RECORDS MANAGEMENT CONSIDERATIONS.** This instruction has been thoroughly reviewed during the directives clearance process, and it has been determined there are no further records scheduling requirements, in accordance with Federal Records Act, 44 U.S.C. 3101 et seq., NARA requirements, and information and Life Cycle Management Manual, COMDTINST M5212.12 (series). This policy does not have any significant or substantial change to existing records management requirements.
9. **EQUITY CONSIDERATION.** The development of this instruction and the policies contained within have been thoroughly reviewed by the originating office in conjunction with the Office of Inclusion and Diversity (OID). This instruction will not perpetuate implicit bias, stereotypes, or other forms of discrimination and will not intentionally or unintentionally create barriers or inequities that reinforce or result in equity gaps for members of the applicable community.
10. **PROCEDURES.** Candidates must be separated from CGA before submitting their readmission package and must be compliant with reference (c). Former cadets shall submit their readmission package to the Director of Admissions no later than three months (90 days) prior to the start of the semester of which they wish to re-enter CGA. The readmission package shall be submitted via two means: (1) PDF electronic document; and (2) hard copy as prescribed by the Director of Admissions. The readmission package shall be routed to the Superintendent along with the candidate's official Cadet Record. An example readmission package is provided in Enclosures (1) – (8).
 - a. The contents of the readmission package shall include:
 - (1) A written memorandum, not to exceed two pages, that articulates why the candidate should be afforded an additional opportunity to commission as an officer through the CGA. The candidate should discuss:
 - (a) Why they desire to be readmitted.
 - (b) The steps to be taken, if readmitted, to ensure they will serve as a Leader of Character and contribute to the Corps of Cadets.
 - (c) How they have improved or remediated any previously identified leader and/or character deficiencies that may have resulted in their disenrollment
 - (2) A letter of recommendation from the candidate's current Commanding Officer or Officer in Charge, if serving in the Coast Guard's enlisted workforce, or from the candidate's second line supervisor if a civilian, that details their performance, ability, behavior, leadership, judgment, and maturity.
 - (3) A letter of recommendation from the candidate's current immediate supervisor that details their performance, teamwork, initiative, and ability to earn all required qualifications for their assigned billet, if applicable.
 - (4) No more than two additional letters of recommendation from previous academic advisors, academic instructors, coaches, etc.
 - (5) Copies of all awards, CG-3307s, and qualifications earned (if applicable).

- (6) College transcripts (if applicable).
- (7) Results of a self-administered CGA Physical Fitness Exam (PFE) or a Coast Guard Basic Physical Fitness Test (PFT).
- (8) Weigh-in data verified through the candidate's assigned unit or civilian physician.
- (9) A physical exam to ensure compliance with reference (d). If the candidate is not serving in the enlisted workforce, they shall schedule an appointment with the Coast Guard Health, Safety and Work-Life Regional Practice New London (i.e., CGA Clinic).
- (10) Most recent Enlisted Evaluation Report (EER), if applicable.
- (11) Any other applicable information or documentation.

b. The following will disqualify a candidate for readmission:

- (1) Unsatisfactory conduct mark on an EER.
- (2) Any mark less than a four (4) on an EER.
- (3) The member was brought to a Non-Judicial Punishment (NJP) or court-martial proceeding and found guilty of violations of the Uniform Code of Military Justice (UCMJ) or Coast Guard Commandant policy.
- (4) Any arrest or pending legal proceedings.
- (5) Failure to meet Coast Guard weight standards.
- (6) A failure on either the CGA PFE or Coast Guard PFT.
- (7) Substantiated or otherwise validated Civil Rights or AHHI report.

c. Former 1/c cadets that are readmitted but have otherwise fulfilled their academic obligations may be required to complete academic courses at the direction of the Provost.

11. **PROCEDURES (RETURN FROM SABBATICAL)**. Cadets returning from sabbatical must be compliant with reference (c). The readmission package shall be submitted via two means: (1) PDF electronic document; and (2) hard copy as prescribed by the Director of Admissions. The readmission package shall be routed to the Superintendent in conjunction with the candidate's official Cadet Record. The readmission package shall include a written memorandum, not to exceed two pages, that articulates the reason for the cadet's return.

12. **READMISSION PANEL**. For cadets who have been disenrolled or had their cadet appointments involuntarily terminated in accordance with reference (e), the Commandant of Cadets will convene the Coast Guard Academy Readmission Panel (CGARP). The CGARP is intended to review requests for readmission and provide the Superintendent with the opportunity to make a well-informed readmission decision.

SUPTINST 1531.1A

- a. The CGARP shall be chaired by the Assistant Superintendent with the following required participants: (1) Commandant of Cadets; (2) Director of Athletics; (3) Provost; (4) Director of Admissions; (5) Command Master Chief; (6) the Chief Diversity Officer; and if needed (7) the Senior Medical Officer.
- b. The Commandant of Cadets Division will deliver a copy of the former cadet's readmission package to each participant prior to the CGARP convening.
- c. After decision, the CGARP shall make a recommendation on readmission to the Superintendent. Decisions will be made by simple majority with dissenting opinions included in writing for the Superintendent's consideration.

13. FORMS/REPORTS. NONE.

/WILLIAM G. KELLY/
Rear Admiral, U.S. Coast Guard
Superintendent

Encl: (1) Sample Readmission Package: Readmission Memorandum
(2) Sample Readmission Package: Supervisor Memorandum
(3) Sample Readmission Package: CO Memorandum
(4) Sample Readmission Package: Official Transcript
(5) Sample Readmission Package: PFE Scoresheet
(6) Sample Readmission Package: Record of Weigh-In
(7) Sample Readmission Package: DD Form 2808
(8) Sample Readmission Package: Report of Medical History
(9) Readmission Checklist

**U.S. Department of
Homeland Security**

**United States
Coast Guard**



Commanding Officer
U. S. Coast Guard Station XX

Unit Street Address
Mail Stop XXXX
City, State Zip Code
Phone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX
Email: officialemail@uscg.mil

1531
DD Mmm YYYY

MEMORANDUM

From: First Name MI. Last Name, Rank
Former Cadet

To: CG ACADEMY (s)

Subj: LETTER REQUESTING READMISSION

1. I respectfully request to be readmitted to the U.S. Coast Guard Academy for the upcoming Spring Semester.
2. Describe why you desire to be readmitted.
3. The steps you plan to take, if readmitted, to ensure you will serve as a Leader of Character and contribute to the Corps of Cadets.
4. If applicable, describe how you have improved and remediated any deficiencies that may have led to your disenrollment.
5. Thank you for your time and consideration with this matter.

#

**U.S. Department of
Homeland Security**

**United States
Coast Guard**



Commanding Officer
U. S. Coast Guard Station XX

Unit Street Address
Mail Stop XXXX
City, State Zip Code
Phone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX
Email: officialemail@uscg.mil

1531
DD Mmm YYYY

MEMORANDUM

From: First Name MI. Last Name, Rank
Former Cadet Supervisor

To: CG ACADEMY (s)

Subj: LETTER OF RECOMMENDATION

1. I recommend XX to be readmitted to the U.S. Coast Guard Academy.
2. The former cadet's immediate supervisor will write about former cadet XX's performance, ability, behavior, leadership, judgement, and maturity.
3. Thank you for your time and consideration with this matter.

#

**U.S. Department of
Homeland Security**

**United States
Coast Guard**



Commanding Officer
U. S. Coast Guard Station XX

Unit Street Address
Mail Stop XXXX
City, State Zip Code
Phone: (XXX) XXX-XXXX
Fax: (XXX) XXX-XXXX
Email: officialemail@uscg.mil

1531
DD Mmm YYYY

MEMORANDUM

From: First Name MI. Last Name, Rank
Former Cadet Commanding Officer

To: CG ACADEMY (s)

Subj: LETTER OF RECOMMENDATION

1. I recommend XX to be readmitted to the U.S. Coast Guard Academy.
2. The Commanding Officer/Officer in Charge will write about former cadet XX's performance, ability, behavior, leadership, judgement, and maturity.
3. Thank you for your time and consideration with this matter.

#

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Enclosure (4)



U.S. Coast Guard Academy

PHYSICAL FITNESS SCORESHEET

INSTRUCTIONS



CORRECT MARKS



INCORRECT MARKS



1. Do NOT use felt tip, ballpoint or ink pens.
 2. Completely blacken bubbles.
 3. Make clean erasures.
 4. Make no stray marks.

DELIBERATE ENTRY OF A FALSE SCORE IS AN HONOR OFFENSE

I. INFORMATION SECTION

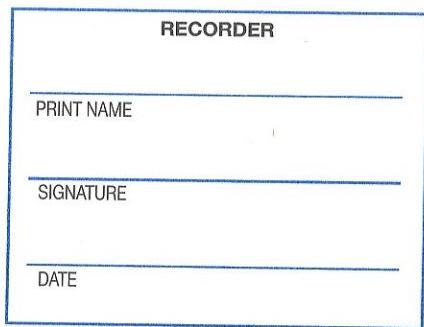
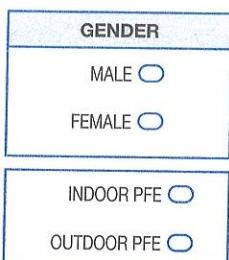
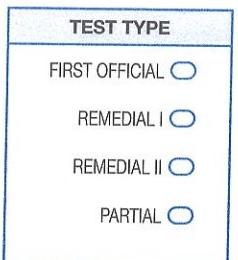
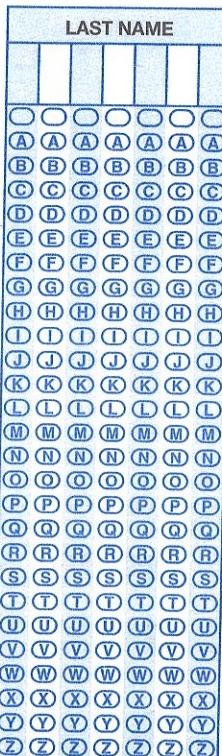
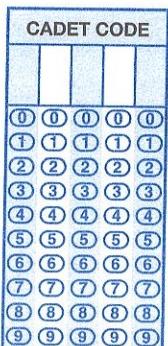
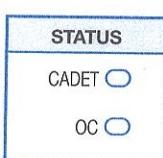
PLEASE PRINT

NAME _____

COMPANY _____ CLASS _____

SIGNATURE

SIGNATURE INDICATES TEST IS COMPLETE
AND SCORES ARE CORRECT



II. PERFORMANCE SECTION

NUMBER	
(0)	(0)
(1)	(1)
(2)	(2)
(3)	(3)
(4)	(4)
(5)	(5)
(6)	(6)
	(7)
	(8)
	(9)

2.) TWO MINUTE CURL-UPS	
	NUMBER
(1)	(1)
(1)	(1)
(2)	(2)
(3)	(3)
(4)	(4)
(5)	(5)
(6)	(6)
(7)	(7)
(8)	(8)
(9)	(9)

3.) 1.5 MILE RUN	
MIN.	SEC.
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

INDOOR RUN SPLITS		TO GO
0.5	○	13
1.5	○	12
2.5	○	11
3.5	○	10
4.5	○	9
5.5	○	8
6.5	○	7
7.5	○	6
8.5	○	5
9.5	○	4
10.5	○	3
11.5	○	2
12.5	○	1
13.5	○	

OUTDOOR RUN SPLITS		TO GO
1	○	6
2	○	5
3	○	4
4	○	3
5	○	2
6	○	1

DID NOT FINISH

COACH / TRAINER NAME

SIGNATURE

DATE

Record of Semi-Annual Weigh-In

DATE: _____

EMPLID: _____ NAME: _____ AGE: _____

BLOCK 1: All members, initial screening, no shoes

Height Round to nearest whole number	inches
MAX Allowable weight per BMI table	pounds
Weight Round to nearest whole number	pounds

- ✓ ODU w/ blouse - subtract 4.0 lbs.
- ✓ Tropical Blue or organizational clothing - subtract 3 lbs.
- ✓ T-shirt and trousers or sweatpants - subtract 2 lbs.
- ✓ T-shirt and gym shorts - subtract 1 lb.

BLOCK 2: Body fat determination (if needed)

AGE	MAXIMUM BODY FAT		Enter MAX body fat %
	MEN	WOMEN	
LESS THAN 30	22%	32%	
LESS THAN 40	24%	34%	
40 and above	26%	36%	
Enter Circumference Value as determined below			inches
Enter Body fat from CIM 1020.8H enclosure (2)			%

HEIGHT	WEIGHT
58	131
59	136
60	141
61	145
62	150
63	155
64	160
65	165
66	170
67	175
68	180
69	186
70	191
71	197
72	202
73	208
74	214
75	220
76	225
77	231
78	237
79	244
80	250

Compliant? Y _____ N _____

Circumference Value determination:

Waist Round down to nearest half-inch. Measure over the bellybutton for males, smallest point for females.	+ Buttocks (females only, use 0 for males) Round down to nearest half-inch. Measure the widest point when viewed from side.	- Neck Round up to nearest half- inch, measure below larynx	= Total
Set 1	+	-	=
Set 2	+	-	=
Set 3	+	-	=

Compare the three totals. Is any difference greater than 1.0?

Set 1 total _____ - Set 2 total _____ = _____
 Set 2 total _____ - Set 3 total _____ = _____ } Are any of these differences greater than 1.0?
 Set 3 total _____ - Set 1 total _____ = _____

No. All totals are within 1.0 inches of each other. Enter lowest total of the three sets as the Circumference Value for block 2.
Yes. Complete an additional set of measurements and then calculate an average circumference value using only the three closest set totals. Set 4: Waist _____ + Buttocks (females) _____ - Neck _____ = Total _____ Add the three closest totals from sets 1-4 together then divide by three to find an average. Round the average down to the nearest 0.5: (_____ + _____ + _____) ÷ 3 = _____ circumference value to enter in block 2

I agree that the above measurements are accurate (print and sign):

Member: _____

Cmnd Cadre &/or Witness: _____

Witness &/or entered by: _____

Prescribed by: DoDI 1304.2

REPORT OF MEDICAL EXAMINATION		1. DATE OF EXAMINATION (YYYYMMDD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (if applicable)																																																																																																																																												
PRIVACY ACT STATEMENT																																																																																																																																																
<p>AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, Regular components: qualifications, term, grade; 10 U.S.C. 507, Extension of enlistment for members needing medical care or hospitalization; 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training; Retirement, as amended.</p> <p>PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.</p> <p>ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcid.defense.gov/Privacy/GORNsIndex/DoD-wide-GORN-Article-View/Article/570661/a0601-270-usmepcom-dod/</p> <p>DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.</p>																																																																																																																																																
3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)		4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)		5a. HOME TELEPHONE NUMBER (Include Area Code)																																																																																																																																												
6. GRADE/ RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9a. BIRTH SEX	9b. PREFERRED GENDER	10a. ETHNIC CATEGORY	10b. RACIAL CATEGORY (Select one)																																																																																																																																										
			<input type="checkbox"/> Male	<input type="checkbox"/> Male	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian																																																																																																																																									
			<input type="checkbox"/> Female	<input type="checkbox"/> Female	<input type="checkbox"/> Non Hispanic/Latino	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White																																																																																																																																									
11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)			13. ORGANIZATION UNIT AND UIC/CODE																																																																																																																																											
a. MILITARY	b. CIVILIAN																																																																																																																																															
14a. RATING OR SPECIALTY (Aviators Only)			14b. TOTAL FLYING TIME			14c. LAST SIX MONTHS																																																																																																																																										
16a. SERVICE		16b. COMPONENT		16c. PURPOSE OF EXAMINATION		18. NAME OF EXAMINING LOCATION, AND ADDRESS (Include Zip Code)																																																																																																																																										
<input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard		<input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard		<input type="checkbox"/> Enlistment <input type="checkbox"/> Commission <input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Other _____		<input type="checkbox"/> Retirement <input type="checkbox"/> U.S. Service Academy <input type="checkbox"/> ROTC Scholarship Program <input type="checkbox"/> Medical Board																																																																																																																																										
MEDICAL EVALUATION (Check each item in appropriate column. Enter "NE" if not evaluated.) <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Normal</th> <th>Abnormal</th> <th>NE</th> </tr> </thead> <tbody> <tr> <td>17. Head, face, neck and scalp</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>18. Nose</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>19. Sinuses</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>20. Mouth and throat</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>21. 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(Please explain. Use dental form if completed by dentist. If abnormality noted, explain in Item 44.) Class _____																																																																																																																																																
44. NOTES: (Mandatory comment for every abnormality identified in Items 17 - 43. Enter pertinent item number before each comment. Continue comments or use drawings in Item 69 and use additional sheets if necessary.)																																																																																																																																																

Prescribed by: DoDI 1304.2

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)												SOCIAL SECURITY NUMBER				DoD ID NUMBER			
LABORATORY FINDINGS																			
45. URINALYSIS		a. Albumin			b. Sugar			46. URINE HCG		47. H/H			48. BLOOD TYPE						
TESTS		RESULTS						HIV SPECIMEN ID LABEL				DRUG TEST SPECIMEN ID LABEL							
49. HIV																			
60. DRUGS																			
61. ALCOHOL																			
62. OTHER																			
a. PAP SMEAR																			
b. EKG																			
c. CXR																			
MEASUREMENTS AND OTHER FINDINGS																			
63. HEIGHT (in.)		64. WEIGHT (lbs.)		65a. MIN WGT		65b. MAX WGT		65c. MAX BF %		65d. BMI		66. TEMPERATURE		67. HEART RATE					
68. BLOOD PRESSURE								69. RED/GREEN				70. OTHER VISION TEST							
a. 1ST		b. 2ND		c. 3RD															
SYS.	SYS.	SYS.	DIAS.	DIAS.	DIAS.														
81. DISTANCE VISION				82. REFRACTION <input type="checkbox"/> AUTO <input type="checkbox"/> MANIFEST <input type="checkbox"/> CYCLO				83. NEAR VISION											
Right Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Right Uncorr. 20/	Corr. to 20/	Add:	Left Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Left Uncorr. 20/	Corr. to 20/	Add:				
84. HETEROPHORIA																			
ES	EX	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD												
86. ACCOMMODATION				88. COLOR VISION (Pass/Fail and Score)				87. DEPTH PERCEPTION (Pass/Fail and Score)											
Right	Left	PIP	RED/ GREEN	Color Dx	AFVT	RANDOT/ MCST													
88. FIELD OF VISION				89. NIGHT VISION				70. INTRAOCCULAR PRESSURE											
								O.D.	O.S.										
71a. AUDIOMETER Unit Serial Number				71b. Unit Serial Number				72a. READING ALOUD TEST:	<input type="checkbox"/>	SAT	<input type="checkbox"/>	UNSAT							
Date Calibrated (YYYYMMDD)				Date Calibrated (YYYYMMDD)				72b. VALSALVA:	<input type="checkbox"/>	SAT	<input type="checkbox"/>	UNSAT							
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	72e. OTHER TESTING					
Left							Left												
Right							Right												
73. NOTES AND/OR INTERVAL HISTORY																			

Prescribed by: DoDI 1304.2

LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)					SOCIAL SECURITY NUMBER			DoD ID NUMBER			
74. EXAMINEE					75. I have been advised of my disqualifying condition(s).						
<input type="checkbox"/> IS MEDICALLY QUALIFIED <input type="checkbox"/> IS NOT MEDICALLY QUALIFIED					75a. SIGNATURE OF EXAMINEE			75b. DATE (YYYYMMDD)			
76. PHYSICAL PROFILE											
P	U	L	H	E	S	X	D	PROFILER INITIALS	DATE (YYYYMMDD)		
77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES											
ITEM NO.	MEDICAL DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE (YYYYMMDD)	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED			
								SERVICE	DATE (YYYYMMDD)		
78. SUMMARY OF MEDICAL DIAGNOSES (List diagnoses with item numbers) (Use additional sheets if necessary).											
79. RECOMMENDATIONS (Specify) (Use additional sheets if necessary).											
80. MEPS WORKLOAD (For MEPS use only)											
WKID	ST	DATE (YYYYMMDD)	INITIALS		WKID	ST	DATE (YYYYMMDD)	INITIALS			
81. MEDICAL INSPECTION DATE			HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE	
82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER							82b. Signature				
83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER							83b. Signature				
84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)							84b. Signature				
85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY (Indicate which)							85b. Signature				
88. This examination has been administratively reviewed for completeness and accuracy.											
a. SIGNATURE				b. GRADE				c. DATE (YYYYMMDD)			
87. WAIVER GRANTED (If yes, date and by whom)					YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	88. NUMBER OF ATTACHED SHEETS		

Prescribed by: DoDI 1304.2

88. ADDITIONAL REMARKS

CUI (when filled in)

OMB No. 0704-0413
 OMB approval expires
 20241031

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at wts.mc-alex.esd.mbx.dd-dod-information-collection@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 138, Under Secretary of Defense For Personnel and Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening from (DD 2807-2Y). An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.

ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: <http://ddcik.dod.mil/Privacy/SORNs/Index/DOD-wide-SORN-Article-View/Article570661/a0801-270-usepcpm-dod/>

DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. An applicant's SSN is used during the recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a \$10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a SOCIAL SECURITY NO.	b. DoD ID NO. (If applicable)	3. TODAY'S DATE (YYYYMMDD)
4.a. HOME ADDRESS (Street, Apartment No., City, State, and ZIP Code)	5. EXAMINING LOCATION AND ADDRESS (Include Zip Code)		
b. HOME TELEPHONE (Include Area Code)			
c. EMAIL ADDRESS			

X ALL APPLICABLE BOXES:			7.a. POSITION (Title, Grade, Component)
6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	
<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Coast Guard <input type="checkbox"/> Regular <input type="checkbox"/> Reserve <input type="checkbox"/> National Guard	<input type="checkbox"/> Retention <input type="checkbox"/> Separation <input type="checkbox"/> Medical Board <input type="checkbox"/> Retirement <input type="checkbox"/> Other (Specify)	b. USUAL OCCUPATION
8. CURRENT MEDICATIONS (Prescription and Over-the-Counter)		9. ALLERGIES (Including Insect bites/stings, foods, medicine, or other substance)	

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	12. (Continued)	YES	NO
10.a. Tuberculosis	<input type="radio"/>	<input type="radio"/>	f. Foot trouble (e.g., pain, corns, bunions, etc.)	<input type="radio"/>	<input type="radio"/>
b. Lived with someone who had tuberculosis	<input type="radio"/>	<input type="radio"/>	g. Impaired use of arms, legs, hands, or feet	<input type="radio"/>	<input type="radio"/>
c. Coughed up blood	<input type="radio"/>	<input type="radio"/>	h. Swollen or painful joint(s)	<input type="radio"/>	<input type="radio"/>
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	<input type="radio"/>	<input type="radio"/>	i. Knee trouble (e.g., locking, giving out, pain or ligament injury, etc.)	<input type="radio"/>	<input type="radio"/>
e. Shortness of breath	<input type="radio"/>	<input type="radio"/>	j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	<input type="radio"/>	<input type="radio"/>
f. Bronchitis	<input type="radio"/>	<input type="radio"/>	k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts, or orthosis, etc.	<input type="radio"/>	<input type="radio"/>
g. Wheezing or problems with wheezing	<input type="radio"/>	<input type="radio"/>	l. Bone, joint, or other deformity	<input type="radio"/>	<input type="radio"/>
h. Been prescribed or used an Inhaler	<input type="radio"/>	<input type="radio"/>	m. Plate(s), screw(s), rod(s), or pin(s) in any bone	<input type="radio"/>	<input type="radio"/>
i. A chronic cough or cough at night	<input type="radio"/>	<input type="radio"/>	n. Broken bone(s) (cracked or fractured)	<input type="radio"/>	<input type="radio"/>
j. Sinusitis	<input type="radio"/>	<input type="radio"/>	13.a. Frequent indigestion or heartburn	<input type="radio"/>	<input type="radio"/>
k. Hay fever	<input type="radio"/>	<input type="radio"/>	b. Stomach, liver, intestinal trouble, or ulcer	<input type="radio"/>	<input type="radio"/>
l. Chronic or frequent colds	<input type="radio"/>	<input type="radio"/>	c. Gall bladder trouble or gallstones	<input type="radio"/>	<input type="radio"/>
11.a. Severe tooth or gum trouble	<input type="radio"/>	<input type="radio"/>	d. Jaundice or hepatitis (liver disease)	<input type="radio"/>	<input type="radio"/>
b. Thyroid trouble or goiter	<input type="radio"/>	<input type="radio"/>	e. Rupture/hemorrhoid	<input type="radio"/>	<input type="radio"/>
c. Eye disorder or trouble	<input type="radio"/>	<input type="radio"/>	f. Rectal disease, hemorrhoids, or blood from the rectum	<input type="radio"/>	<input type="radio"/>
d. Ear, nose, or throat trouble	<input type="radio"/>	<input type="radio"/>	g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	<input type="radio"/>	<input type="radio"/>
e. Loss or vision in either eye	<input type="radio"/>	<input type="radio"/>	h. Frequent or painful urination	<input type="radio"/>	<input type="radio"/>
f. Worn contact lenses or glasses	<input type="radio"/>	<input type="radio"/>	i. High or low blood sugar	<input type="radio"/>	<input type="radio"/>
g. A hearing loss or wear a hearing aid	<input type="radio"/>	<input type="radio"/>	j. Kidney stone or blood in urine	<input type="radio"/>	<input type="radio"/>
h. Surgery to correct vision (RK, PRK, LASIK, etc.)	<input type="radio"/>	<input type="radio"/>	k. Sugar or protein in urine	<input type="radio"/>	<input type="radio"/>
12.a. Painful shoulder, elbow or wrist (e.g. pain, dislocation, etc.)	<input type="radio"/>	<input type="radio"/>	l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	<input type="radio"/>	<input type="radio"/>
b. Arthritis, rheumatism, or bursitis	<input type="radio"/>	<input type="radio"/>	14.a. Adverse reaction to serum, food, insect stings, or medicine	<input type="radio"/>	<input type="radio"/>
c. Recurrent back pain or any back problem	<input type="radio"/>	<input type="radio"/>	b. Recent unexplained gain or loss of weight	<input type="radio"/>	<input type="radio"/>
d. Numbness or tingling	<input type="radio"/>	<input type="radio"/>	c. Currently in good health (If no, explain in Item 29 on Page 2.)	<input type="radio"/>	<input type="radio"/>
e. Loss of finger or toe	<input type="radio"/>	<input type="radio"/>	d. Tumor, growth, cyst, or cancer	<input type="radio"/>	<input type="radio"/>

CUI (when filled in)

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (If applicable)
Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.		
HAVE YOU EVER HAD OR DO YOU NOW HAVE:		YES NO
15.a. Dizziness or fainting spells <input type="radio"/> <input checked="" type="radio"/> b. Frequent or severe headache <input type="radio"/> <input checked="" type="radio"/> c. A head injury, memory loss or amnesia <input type="radio"/> <input checked="" type="radio"/> d. Paralysis <input type="radio"/> <input checked="" type="radio"/> e. Seizures, convulsions, epilepsy, or fits <input type="radio"/> <input checked="" type="radio"/> f. Car, train, sea, or air sickness <input type="radio"/> <input checked="" type="radio"/> g. A period of unconsciousness or concussion <input type="radio"/> <input checked="" type="radio"/> h. Meningitis, encephalitis, or other neurological problems <input type="radio"/> <input checked="" type="radio"/>		
16.a. Rheumatic fever <input type="radio"/> <input checked="" type="radio"/> b. Prolonged bleeding (as after an injury or tooth extraction, etc.) <input type="radio"/> <input checked="" type="radio"/> c. Pain or pressure in the chest <input type="radio"/> <input checked="" type="radio"/> d. Palpitation, pounding heart or abnormal heartbeat <input type="radio"/> <input checked="" type="radio"/> e. Heart trouble or murmur <input type="radio"/> <input checked="" type="radio"/> f. High or low blood pressure <input type="radio"/> <input checked="" type="radio"/>		
17.a. Nervous trouble of any sort (anxiety or panic attacks) <input type="radio"/> <input checked="" type="radio"/> b. Habitual stammering or stuttering <input type="radio"/> <input checked="" type="radio"/> c. Loss of memory or amnesia, or neurological symptoms <input type="radio"/> <input checked="" type="radio"/> d. Frequent trouble sleeping <input type="radio"/> <input checked="" type="radio"/> e. Received counseling of any type <input type="radio"/> <input checked="" type="radio"/> f. Depression or excessive worry <input type="radio"/> <input checked="" type="radio"/> g. Been evaluated or treated for a mental condition <input type="radio"/> <input checked="" type="radio"/> h. Attempted suicide <input type="radio"/> <input checked="" type="radio"/>		
18. FEMALEs ONLY. Have you ever had or do you now have: a. Treatment for a gynecological (female) disorder <input type="radio"/> <input checked="" type="radio"/> b. A change of menstrual pattern <input type="radio"/> <input checked="" type="radio"/> c. Any abnormal PAP smears <input type="radio"/> <input checked="" type="radio"/> d. First day of last menstrual period (YYYYMMDD) <input type="radio"/> <input checked="" type="radio"/> e. Date of last PAP smear (YYYYMMDD) <input type="radio"/> <input checked="" type="radio"/>		
19. Have you been refused employment, or been unable to hold a job or stay in school because of: a. Sensitivity to chemicals, dust, sunlight, etc. <input type="radio"/> <input checked="" type="radio"/> b. Inability to perform certain motions <input type="radio"/> <input checked="" type="radio"/> c. Inability to stand, sit, kneel, lie down, etc. <input type="radio"/> <input checked="" type="radio"/> d. Other medical reasons (If yes, give reasons.) <input type="radio"/> <input checked="" type="radio"/>		
20. Have you ever been treated in an Emergency Room? (If yes, for what?) <input type="radio"/> <input checked="" type="radio"/>		
21. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) <input type="radio"/> <input checked="" type="radio"/>		
22. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.) <input type="radio"/> <input checked="" type="radio"/>		
23. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) <input type="radio"/> <input checked="" type="radio"/>		
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) <input type="radio"/> <input checked="" type="radio"/>		
25. Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.) <input type="radio"/> <input checked="" type="radio"/>		
26. Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) <input type="radio"/> <input checked="" type="radio"/>		
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.) <input type="radio"/> <input checked="" type="radio"/>		
28. Have you ever been denied life insurance? <input type="radio"/> <input checked="" type="radio"/>		
29. EXPLANATION OF "YES" ANSWER(S) (Describe answer(s), give date(s) of problem, name of doctor(s)and/or hospital(s), treatment given and current medical status.)		
NOTE: HAND TO THE DOCTOR OR NUSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."		

CUI (when filled in)

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER (if applicable)
30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)		
a. COMMENTS		
b. TYPED OR PRINTED NAME OF EXAMINER (Last, First, Middle Initial)	c. SIGNATURE 	d. DATE SIGNED (YYYYMMDD)

Updated: August 2022

Readmitted Cadet Check In Sheet

Cadet Name:

Company:

PHASE I (To be completed within 48 hours of arrival)	Date/Initials: <input type="checkbox"/> / <input type="checkbox"/> Make an appointment with cadet admin to obtain a new CAC card <input type="checkbox"/> / <input type="checkbox"/> Check in with the IT department to establish internet and email access <input type="checkbox"/> / <input type="checkbox"/> Provide hard copy of medical record to the CGA Clinic <input type="checkbox"/> / <input type="checkbox"/> Make an appointment with the clinic for a physical exam <input type="checkbox"/> / <input type="checkbox"/> Check in with Company Officer <input type="checkbox"/> / <input type="checkbox"/> Check in with Company Chief
PHASE II (To be completed within 72 hours of arrival)	Date/Initials: <input type="checkbox"/> / <input type="checkbox"/> Complete urinalysis screening with Cadet Admin <input type="checkbox"/> / <input type="checkbox"/> Complete weigh-in with Cadet Admin <input type="checkbox"/> / <input type="checkbox"/> Check in with the Assistant Commandant of Cadets <input type="checkbox"/> / <input type="checkbox"/> Check in with the cadet mailroom to be assigned a new mailbox <input type="checkbox"/> / <input type="checkbox"/> File travel claim via E2/ETS
PHASE III (To be completed within 1 week of arrival)	Date/Initials: <input type="checkbox"/> / <input type="checkbox"/> Meet with Academic Advisor, Draft Plan of Study <input type="checkbox"/> / <input type="checkbox"/> Check in with Coach (if applicable) <input type="checkbox"/> / <input type="checkbox"/> Check in with the uniform shop, tailor shop, and bookstore to ensure your seabag is IAW your new class <input type="checkbox"/> / <input type="checkbox"/> Submit paperwork to CGPD for POV approval and parking pass (if applicable) <input type="checkbox"/> / <input type="checkbox"/> Finish moving in, prepare for a room inspection
PHASE IV (To be completed within two weeks of arrival)	Date/Initials: <input type="checkbox"/> / <input type="checkbox"/> Complete physical exam <input type="checkbox"/> / <input type="checkbox"/> Complete PFE

Notes:

If you are unable to meet the deadlines prescribed in this checklist, inform your Company Officer and/or

Chief as early as possible.

File completed checklist in your cadet record.